



1907-001	\$400.00
1907-006	\$ 10.00
TOTAL	\$410.00

State of Tennessee
Department of Health
Health Related Boards
665 Mainstream Drive
Nashville, TN 37243

TENNESSEE BOARD OF OSTEOPATHIC EXAMINATION

(615) 532-3202, ext. 532-4384 or (800) 778-4123, ext. 532-4384

APPLICATION FOR A LOCUM TENENS LICENSE AS AN OSTEOPATHIC DOCTOR

ATTACH THE FOLLOWING TO THIS APPLICATION AND MAIL TO : Board of Osteopathic Examination
665 Mainstream Drive
Nashville, TN 37243

1. A check or money order for \$410.00, payable to the Tennessee Board of Osteopathic Examination.
2. A clear and recognizable, recently taken, bust photograph that shows the full head, face forward from at least the shoulders up.
3. Evidence of current licensure in good standing in another state (only need one). Use Attachment 2
4. A notarized copy of a specialty certification from a recognized specialty or a letter from your training program director which states that you are eligible to apply for the certification examination.
5. Proof of citizenship in the United States or Canada, or evidence of being legally entitled to live and work in the United States (Notarized copies of birth certificates, naturalization papers, resident alien cards, green cards, current H-1 Visa status, U.S. passport, or voter registration are acceptable.)
6. Complete and submit along with your application the Practitioner Profile Questionnaire which is online at <http://tn.gov/assets/entities/health/attachments/PH-3585.pdf>. You are required by law update your profile within 30 days of any change as long as you have an active license. Failure to do so may subject you to disciplinary action.
7. Criminal Background Check. For instructions to obtain a criminal background check, go to <http://tn.gov/health/article/CBC-instructions>
8. Complete Attachment 3 – Declaration of Citizenship

PERSONAL INFORMATION

Applicant's Name: _____
(First) (Middle and/or Maiden) (Last)

Date of Birth : _____ Social Security Number: _____ - _____ - _____
(Month) (Day) (Year)

Present Home Mailing Address: _____

Home Phone: () _____ Work Phone: () _____

Name of Medical School: _____

Year Graduated: _____

Intended location of initial work in Tennessee: _____

Intended duration of initial work in Tennessee: _____

E-mail address: _____

Do you wish to receive notification, including renewal notification, from the Department of Health, via email? Y N

INITIAL PRACTICE SETTING

Briefly describe the reason why this license is desired and the situation in which it will be used.

LICENSURE INFORMATION

List below **ALL STATES, COUNTRIES OR PROVINCES** in which you **HAVE EVER BEEN OR ARE CURRENTLY** licensed as an osteopathic doctor. Additional pages may be added if necessary.

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS
<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>
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COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the **affirmative**, attach an explanation on a separate sheet. **In support of your explanation, the final documents or orders from the issuing states, courts, and/or agencies must be submitted along with this application.**

For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice medicine"** is to be construed to include all of the following:
 - a. The cognitive capacity to make appropriate clinical diagnosis and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and
 - b. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
 - c. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

COMPETENCY INFORMATION continued

2. **"Medical Condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV, tuberculosis, drug addiction and alcoholism.
3. **"Chemical substances"** is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
4. **"Currently"** does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee, or within the past two (2) years.
5. **"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g. heroin, or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS:

YES

NO

1. Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?
 - a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program?
 - b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice?

[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.]
2. Do you currently use chemical substances?
3. Are you currently engaged in the illegal use of controlled substances?
 - a. If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?
4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?

COMPETENCY INFORMATION continued

	YES	NO
5. If you have ever held or applied for a license or certificate to practice medicine in any state, country or province, has or was it ever been denied, reprimanded, suspended, restricted, revoked, or otherwise disciplined, curtailed or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
6. If you have ever had staff privileges at any hospital or health care facility have they ever been revoked, suspended, curtailed, restricted, limited or otherwise disciplined or voluntarily surrendered under threat of restriction or disciplinary action?	_____	_____
7. Have you ever failed a medical licensure examination?	_____	_____
8. Have you ever applied for and been denied a state or federal controlled substance certificate?	_____	_____
a. If you have possessed such a certificate has it ever been revoked, suspended, restricted or otherwise disciplined or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
9. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic offense?	_____	_____
10. Have you ever been rejected or censured by a medical society?	_____	_____
11. In relation to the performance of your professional services in any profession:	_____	_____
a. Have you ever had a final judgment rendered <u>against</u> you; or	_____	_____
b. Have you ever had settlement of any legal action rendered <u>against</u> you; or	_____	_____
c. Are there any legal actions pending <u>against</u> you or to which you are a party?	_____	_____
12. If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, or otherwise disciplined, curtailed or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
	_____	_____

APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC

AFFIDAVIT AND RELEASE

I, _____, D.O., of _____
(City) (State)

being duly sworn and identified as the person referred to in this application, attests to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations which were enclosed in the application packet and agree to abide by them in the practice of medicine in the State of Tennessee. I **HEREBY:**

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary which may include a full Board interview.

RELEASE to the Board, its staff and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice medicine.

AUTHORIZE the Board, its staff and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications.

RELEASE from liability the Board, its staff and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character and other qualifications for licensure.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical and other qualifications and for resolving any doubts about such qualifications.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE

DATE

Sworn to before me, this ____ day of _____, _____.

NOTARY PUBLIC

Affix Seal Here

My Commission expires:



State of Tennessee
Department of Health
Health Related Boards
665 Mainstream Drive
Nashville, TN 37243

BOARD OF OSTEOPATHIC EXAMINATION

LOCUM TENENS

NOTIFICATION OF PRACTICE SETTING

Next Practice Setting Dates

Next Practice Setting Location

Please describe the reason for this practice:

(If the reason is to substitute or provide coverage, include the doctor's name and specialty)

Name _____

Date _____

Signature _____ **License # D.O.L.T.** _____



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CLEARANCE FROM OTHER STATE LICENSURE BOARDS

APPLICANT: Please provide the information requested in the top box and then mail one form to the licensure board in EACH state where you hold OR HAVE EVER HELD a license to practice any profession. (Copies of this form can be used.) **NOTE:** Some states require a fee for providing clearance information. To expedite your application, you may wish to contact the applicable state(s).

_____ (Name of Applicant)	was granted a license to practice _____ (Profession)
with license number _____ on _____ (Date)	in the State of _____
The Board of Osteopathic Examination of Tennessee requests that I submit evidence of the current status of that license in your state. You are hereby authorized to release any information in your files, favorable or otherwise, directly to: <div style="text-align: center;"> State of Tennessee Board of Osteopathic Examination 665 Mainstream Drive Nashville, TN 37243 </div>	
Date: _____	_____ Applicant's Signature
_____ Applicant's typed or printed name	

ADMINISTRATIVE OFFICE OF STATE LICENSURE BOARD, PLEASE COMPLETE:			
Name In Full As It Appears On License: _____			
License Number: _____	Profession: _____	Date Issued: _____	
Basis of issuance: _____ (Check One)	Endorsement/Reciprocity with: _____ (State)		
_____ Written Examination:	_____ (Name of Exam)		
The License is currently active and registered?			
yes no			
Is there any derogatory information on file?			
yes no	If yes, an explanation must be attached.		
_____ Authorized Signature	_____ Title	_____ Date	



**STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243**

**DECLARATION OF CITIZENSHIP
MUST ACCOMPANY ALL APPLICATIONS FOR INITIAL LICENSURE OR REINSTATEMENT OF LICENSURE**

The "SAVE Act" requires Tennessee Department of Health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that *every adult* applicant for a professional license is either a U.S. citizen, a "qualified alien," or a nonimmigrant who meets the requirements set out at 8 U.S.C. 1621.

I am a(n) _____
Healthcare Profession (Please Print)
License number if applicable

Please Print Legibly

1. Name: _____

Last
First
Middle
Maiden_
2. Mailing Address: _____
3. Phone Number: Home: (____)____-____ Office: (____)____-____ Fax: (____)____-____
4. I am a United States Citizen: ____Yes ____No
5. I am a foreign national not physically present in the United States ____Yes ____No. If you answered yes, to this question please sign this form in the presence of a notary and return it with your application. No further documentation is required.
6. Applicants Claiming United States Citizenship **MUST** provide one of the following:
 - a) Tennessee Driver's License, or photo ID issued by Department of Safety.
 - b) A valid driver license or ID issued by another state, provided its issuance requirements meet Department of Safety criteria.
 - c) An official birth certificate issued by a U.S. state, territory, or other jurisdiction. Puerto Rican birth certificates issued before July 1, 2010 do not count.
 - d) A federally issued birth certificate.
 - e) A valid, unexpired U.S. passport.
 - f) A report of birth abroad of a U.S. citizen.
 - g) A certificate of citizenship.
 - h) A certificate of naturalization.
 - i) A U.S. citizen ID card.
 - j) Any successor document to #'s a-i above.
 - k) SSN that the entity or local health department may verify with the Social Security Administration in accordance with federal law.
7. If you checked "No" in question 4 please indicate from the list below which category applies to you: (circle one)
 - a) Permanent Residents

- b) A nonimmigrant applicant for a professional or commercial license whose visa for entry into the United States is related to such employment, or a nonimmigrant under the Immigration and Nationality Act (8 U.S.C. 1101 *et seq.*).
- c) Asylees who meet the qualifications set out in 8 U.S.C. 1158
- d) Refugees who meet the qualifications set out in 8 U.S.C. 1157
- e) Persons who have been "paroled into the United States," under 8 U.S.C. 1182(d)(5) or whose deportation has been withheld under 8 U.S.C. 1253.
- f) Cuban or Haitian entrants as defined by section 501(e) of the Refugee Education Assistance Act of 1980
- g) Persons granted conditional entry into the U.S. under 8 U.S.C. 1153(a)(7) before April 1, 1980, because of persecution or fear of persecution on account of race, religion, or political opinion or because of being uprooted by catastrophic national calamity.
- h) An alien who has been "battered" or subjected to "extreme cruelty" by a parent or spouse as defined by 8 U.S.C. 1641(c), and also meets the qualifications set out 8 U.S.C. 1641(c)(1)(B). Under the circumstances set out in 8 U.S.C. 1641(c)(2) and (3), victims' children, or the parents of children who are victims, may also apply for benefits as qualified aliens.

Applicants claiming **qualified alien status** (question 7 above), please submit two of the following forms of "documentation of identity and immigration status" as determined by U.S. Homeland Security to be acceptable for verification through the SAVE program. Common types of documents used to verify immigration status are listed below. (Note: If you can provide only one document, your status will be verified through the U.S. Department of Homeland Security's SAVE program):

I-327 (Reentry Permit)

I-551 (Permanent Resident Card or "Green Card")

I-571 (Refugee Travel Document)

I-766 (Employment Authorization Card)

Machine Readable Immigrant Visa (with Temporary I-551 language)

Temporary I-551 stamp (on passport or I-94)

I-94 (Arrival/Departure record)

Unexpired foreign passport

WT/WB Admission Stamp in unexpired foreign passport

I-20 (Certificate of Eligibility for Nonimmigrant F(1) student status- "student visa")

DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)

I affirm under the penalty of perjury that the above is true and correct.

Signed this ____ day of _____, 20__.

Signature

Sworn to before me this ____ day of _____, 20__.

NOTARY PUBLIC

AFFIX SEAL HERE

My Commission Expires: _____

If an applicant is discovered to be an unqualified alien, or otherwise ineligible for benefits under the Act, all recurring benefits provided to that applicant must be immediately terminated. Anyone who purposefully makes a false, fictitious, or fraudulent claim of U.S. citizenship or qualified alien status will be liable under the Tennessee Medicaid False Claims Act, or Tennessee's False Claims Act. Any person who conspires to defraud the state or any local health department by securing a false claim allowed or paid to another person in violation of the Act may be liable under Tennessee's False Claims Act. Upon discovery of an applicant's false, fictitious, or fraudulent claim of U.S. citizenship, state governmental entities and local health departments must also file a criminal complaint with the United States Attorney.